THE ROLES AND RESPONSIBILITIES OF LOCAL PUBLIC HEALTH SYSTEMS IN URBAN HEALTH

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ABSTRACT In recent years, policy analysts have paid much attention to the precarious state and uncertain future of local public health departments and so-called safety net providers, usually treating each separately. This paper explores the ways in which these systems are converging, are adapting to a changing health marketplace, and are interacting with new private sector competitors and partners. Although threatened by policy, competitive, and financial forces, many of these local organizations are adapting successfully. An agenda for transforming these entities is described; the agenda emphasizes leadership, democratization, and partnerships with communities.

Local public health systems most often bear front-line responsibility for dealing with many of the health problems of urban America. This paper first explores the evolving definition of public health systems in today's rapidly changing environment. It then examines the forces that are shaping those systems, their responses to change, their traditional and potential roles in changing policy, and what the future demands of them.

WHAT ARE "PUBLIC" HEALTH SYSTEMS?

Local public health systems have traditionally encompassed two broad overlapping sets of entities, depending on which words we emphasize: *public health* systems, which are linked to public and private organizations concerned primarily with the preservation and promotion of public health; and public *health systems*, which are publicly operated systems of personal medical services, focused typically on vulnerable populations. Both are converging now: the former are actively providing clinical services; the latter are beginning to focus on community health. Four principal types of organizations comprise those

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systems: city and county public health departments; public hospitals and clinics; private providers and community-based organizations under contract to or with some formal responsibility to local government (on the order of 60% to 70% of all health departments now contract out services); and, finally, the parties often forgotten in these discussions, the teaching partners to these service entities (universities, schools of health professions, and academic medical centers).

There is no single configuration that we can describe as a public health system in the urban communities of our country. The roles that health departments and public safety net providers play with respect to other providers, educational institutions, and community-based organizations are quite different from area to area. Often, they lead; many times, they trail. The concentration or dispersion of responsibilities that they bear also differs greatly. In many communities, a very small number of readily identifiable institutions carry virtually all of the responsibilities, but in some, these are shared widely. Their disposition with respect to the role of the public entity as a provider, that is, whether the public sector should provide services directly or competitively, also varies considerably. In many communities, a local health department comprises the formal public health system; in a few, such as San Francisco, a single, all-encompassing integrated public entity provides the range of environmental and public health services, community clinics, public hospitals, long-term care, and mental health and substance abuse services. In most, an array of often unlinked public and private providers comprise the "system."

But, regardless of the unique configuration in a particular city, these are networks of services designed to protect and improve the health of the community; to monitor, anticipate, and respond to problems; and to have a particular concern for the vulnerable, the poor, and the underserved. The US Department of Health and Human Services' list of "10 essential services of public health" is a starting point for defining this infrastructure; these points focus less on whether an entity is run by the public sector and more on whether it is fulfilling certain critical functions:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.

6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and ensure the provision of health care when otherwise unavailable.
8. Ensure a competent public health and personal health care workforce.
9. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

The above array of activities should be expected in our cities regardless of labels and auspices. The list also offers the basis, going forward, for a report card that assesses whether a community has an adequate public health infrastructure and how that infrastructure is performing.

PROVIDERS OF PUBLIC HEALTH

A look at some of the emerging players now providing or helping to shape what is done in the name of public health in our cities highlights the fact that public health systems no longer are simply public, and that policy is not simply a matter for government. These participants include private providers, managed-care plans, businesses, employee organizations, other human service entities, and community consumer groups.

Either because of historical mission, competition, or the regulatory pressure of community benefits legislation, many private providers are now finding themselves trying to demonstrate what they do for their community and broadening beyond direct medical services to public health kinds of activities.

Managed-care plans are making tentative forays into population-based health activities, although most of their efforts have thus far been confined to clinical preventive services such as immunization and screening. Managed-care organizations have primarily functioned to this point through risk aversion, that is, by *selecting* people who are healthy rather than *making* people healthy. It is hoped that there will come a time soon when their principal focus is the health of the community, perhaps when their enrollment has stabilized to the point at which they can see an interest in promoting the overall health of their enrollees and the communities in which they live and work.

Private purchasers have received a great deal of attention in the popular press, and in the health care trade press, for aggressive tactics at shaving dollars and "purchasing quality." Unfortunately, we find very little evidence of that pursuit of quality. Nevertheless, there are examples around the country of cities such as Cleveland, Ohio, or Syracuse, New York, in which business has aligned itself with health care organizations in pursuit of high-quality service and a healthy workforce, with an understanding of the critical nexus among strong local institu-

tions, economic development, the health of people, and the well-being of the community.

Employees and unions are also becoming more active in these areas. Broadly known for its advocacy for choice in health care, organized labor is increasingly engaged in efforts like those pursued by the United Auto Workers in partnership with the auto industry in Michigan and Indiana. In these broad-based "community initiatives" that involve labor, business, providers, carriers, and community organizations, the entire delivery system and health apparatus of a community is subjected to a detailed performance review, and plans are made to adopt the best practices in health and health care.

Mental health, substance abuse, and family services are fundamental to a coordinated public health system. Yet, they are still separate systems in most communities. This is finally beginning to change, largely due to the pressure exerted by affected communities rather than by the motivation of professionals and providers, who remain organized around their disciplines or categorical funding streams.

Finally, communities and consumers are increasingly making their voices heard. Effective national policy efforts to reduce lead and other hazards in our environment have received considerable attention. Yet, the other side of that story, in cities like San Francisco, Boston, and New York, is a tale of strong community-based organizations that compel the housing authority or the public health department to take on such issues as a priority. Needle-exchange programs, efforts to reduce violence, workplace safety, and "environmental justice" initiatives are other examples for which official public health organizations have usually followed rather than led. True partnerships with those community organizations and with communities are starting to take place now. The recently initiated Turning Point program, funded by the Robert Wood Johnson and W. K. Kellogg Foundations, is an ambitious national effort to build on these partnerships.

SALIENT FORCES

What are the critical forces that are shaping these public systems today? Obviously, health trends and related knowledge are the principal drivers of change, but public policy, economic and competitive forces, and community values are also shaping these systems and their capabilities.

The dominant element of public policy now is *devolution*, the shift of responsibility and accountability first from the federal government to the states, then from the states to the localities, and then, often, from the localities to private vendors. Dramatic change is occurring at and between each of these levels. At the national level, policy changes in Medicaid, Medicare, graduate medical

education, welfare, immigration, and children's coverage predominate. States are preoccupied not only with their choices and responsibilities under these changing federal programs, but also with Medicaid managed-care implementation, regulation of managed care, and community benefits. Localities are principally concerned with the financial, political, and organizational fallout from these state and national decisions, as well as such issues as whether to continue as providers of service and whether or how to share roles with the private sector.

Powerful economic and competitive forces are challenging the survival of organizations and services that have traditionally been part of the local public health system. The most notable of these, beyond the chronic underfinancing of public health services, are the aggressive discounting by both public and private purchasers, the phenomenon of national investor-owned provider companies and health plans, and the demise of cost shifting, that is, the diminishing ability of providers to use one stream of revenue to subsidize either care for the poor or public health functions. The effects of managed care have been widely discussed. Most often, what is attributed to "managed care" is more precisely the result of a specific economic, competitive, or organizational change. One real factor is the enormous consolidation of health care organizations that is taking place not only at the national level, but also at the regional level, affecting most cities around our country. This consolidation pressures local safety net providers and public health entities to make major investments to be competitive, to align themselves with one of these large emerging conglomerates, or to retreat to a unique and specialized niche.

A third area critical to shaping these public systems is community identity and values. Potent forces of culture, race, and economic power shape people's health and the services to which they have access. Few communities perceive any problem in public health or care for the poor. The strong antitax, antigovernment attitudes in many communities may now be blunted by the rich resources that we seem to have at the moment, but they are certain to resurface. Those attitudes are deeply engrained and undercut the efforts of local public health systems to reshape themselves. However, at the same time, local control and accountability are reasserting themselves as powerful forces. We see communities as diverse as Lansing (Michigan), Cleveland, and Seattle that are dedicated to retaining control of the health resources that they consider their own.

What responses have public health systems made to these powerful forces of change? We have seen a tremendous array of responses, ranging from those that wait and worry to those that rage against the perceived injustice of change. "Crumbling infrastructure" is the term we hear again and again applied to public health at local levels, but that clearly is not the only story. There are also success

stories. Many of those systems have adopted corporate strategies—downsizing, customer-focused services, specialization to compete—while others have focused on partnering and building coalitions. Some of those efforts have been quite successful and much to the benefit of some of our cities; others have been less than successful and have risked their traditional mission in the course of changing. There are also those that are seeking to change into something else, most often a health plan. Finally, there are communities like Denver, Dallas, Flint (Michigan), and Los Angeles, in which the public health leaders are playing a fundamental leadership role in health planning and health policy and the direction of services in their community.

ROLES OF PUBLIC HEALTH SYSTEMS IN SHAPING POLICY

Public health systems are most often viewed as objects of policy: What should national policy do about public health? What should state policy do about the safety net? It is equally important, however, to take the perspective from the local level: What must communities do to change policy?

There is a long tradition of moral leadership from people engaged in public health and in the public sector provision of care. Public health is rooted in traditions of social justice. That imperative is, admittedly, difficult to distinguish from self-interested motives to preserve established institutions and disciplines, but is nonetheless a powerful force that has often worked in the interests of communities. That posture dominated early reactions to managed care. Now, we are starting to see a shift from basically reactive efforts to fight managed care to more sophisticated attempts to shift managed care in the interests of vulnerable populations and of those providers who have typically served them. That strategy is, of course, still mingled with the special interests of some of those providers and professional disciplines, but "leveling the playing field" represents an important force, one that is having more effect every day.

There are two critical types of leadership by which local public health entities can influence policy. The first is leadership in planning, in the application of specialized knowledge, in development of information, and in organizing and arming communities with that information. This is a role that public health systems can play most effectively. It is more of a "servant" role than an elitist position, and it builds on the power of public health entities aligning themselves with communities. The second form of leadership that local public health systems can play is to lead by example. This means identifying and modeling best practices and taking active steps to shift public investments from acute medical care to broader public health needs. In effect, this means moving toward what the Institute of Medicine called "assuring conditions in which people can be healthy."

WHAT DOES THE FUTURE DEMAND OF LOCAL PUBLIC HEALTH SYSTEMS?

Systems that are trying to help shape their own destiny and meet the needs of their communities must take several steps. The first has to do with resolving the dilemma that many health departments have assumed unto themselves: whether they should be the assurer of health or a last-resort provider of health in addition to that. It is critical for local public health systems to resolve this issue quickly and move on to other important things. Such a decision is not trivial. It is becoming fashionable again to talk of returning to the roots of public health, that is, getting out of the direct clinical services business. However, abandoning the provider role entirely means that, if one is to "assure" health, but does not have the capacity to provide services that no one else will provide, the claim of assurance may be hollow. Public systems need to weigh carefully the advantages of a "default" delivery system and the potential for cross subsidies against the distraction from core public health activities that have often accompanied a major delivery system focus. In any case, public health systems must move beyond allegiance to categorical funding sources and deal with the entrenched interests that have grown up around those funding sources.

Second, public health systems need to create a common and accessible language. In public health, and in the health sector in general, we still cling to a language that is not readily accessible to most of the community, and we do not hear the languages that are spoken by most of the communities we need to serve. Related to that is the imperative to democratize science and data. We have traditionally had great access to information, and we have too often used that information and our scientific expertise to create our own power or to sustain it. We need, instead, to make it openly available to people to assess, to use for themselves, in an active way. That is something in which we have a special role to play and can build broad-based capacities in our communities. Such an approach is embodied by New York City's recent development of its Center for Integrated Prevention Programs.

Another challenge is training a public health workforce for the millennium. Public health systems, whether providers of acute medical services or population-based services, have traditionally been the training grounds for a tremendous number of our health and public health professionals and workers around the country. How often have we shaped that training to meet the responsibilities that are incumbent on us and the needs of our communities, as opposed to being the convenient receptacles for that training?

Implementing a research agenda that matters to people and communities is related to the need for a common language and the need to democratize informa-

tion. We have to adjust our research agendas in a way that matters to the communities and the cities that we are working with, not only our own scientific or organizational interests. This means re-establishing relevance, addressing the topics that persistently emerge from our community assessments: not just diseases and disabilities, but violence, drugs, threats to children and the elderly, jobs, and hazardous environments.

Accepting community accountability again relates to information and to the ability to use it in new ways. While there is much talk about "report cards" on the performance of health plans or hospitals, how many public health systems and how many public health entities have subjected themselves to that level of accountability? This is something that we should not fear at all, but should be eager to do in the interests of understanding and improving what we are doing.

Finally, we must move decisively beyond an involuntary constituency of people who have had to use our services because they have no other alternative, and we must demonstrate true value to them and to the entire community. That is a suggested agenda for local public health systems moving forward toward *the public's* health system.